PARIS UNION SCHOOL DISTRICT NO. 95

REQUEST FOR CARRYING & SELF-ADMINISTRATION OF ASTHMA INHALER

Student's Name_____ School _____

Age_____ Grade_____ Allergies _____

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTIONER:

Medication Name/Dosage _____Time_____ Route_____

Disease/illness of student_____

Action of drug_____

Side effects of drug_____

_____

Other Medications Child Is Receiving? _____

To be given until what date? _____

_____ _____

Parent Signature Date

I am prescribing the above medication to be used by the above named student and I certify the student/parent has been instructed in the proper use and care of his/her inhaler. I further understand I will be notified by the school district if the student abuses or misuses the privilege per Public Act #094-0792.

_____

Physician/Nurse Practitioner Signature Phone Number Date

_____

District Nurse Initials Date

The above named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician. Please return completed form to school and give to the school secretary or nurse.